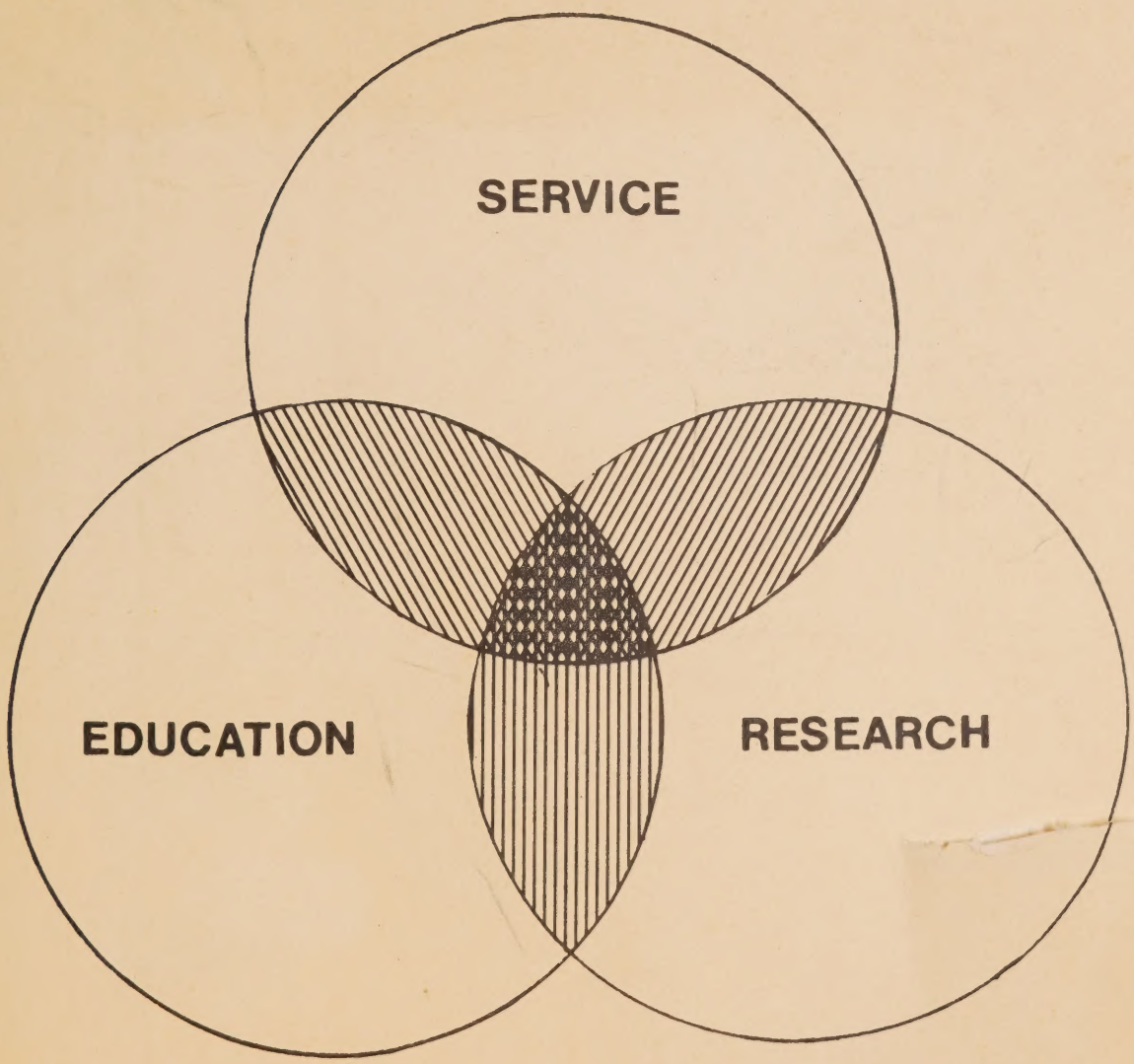
TASK FORCE REPORT

THE FUNDING OF CLINICAL EDUCATION (MEDICINE) IN THE PROVINCE OF ONTARIO



RECOMMENDATIONS FOR CHANGE

February 15, 1977

To the Joint Chairmen
Health Sciences Education Committee
Province of Ontario

Mr. W.A. Backley
Deputy Minister
Ministry of Health

Mr. J.G. Parr
Deputy Minister
Ministry of Colleges & Universities

Dear Sirs:

We respectfully submit herewith our report on The Funding of Clinical Education (Medicine) in the Province of Ontario in accordance with the Terms of Reference listed on pages 3 and 4 herein.

Respectfully

J.W. Aldis (Chairman)

R.B. Holmes

I.W. Bean

A.L. Linton

P.B. Blewett

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Ontario Ministry of Health - Miscellaneous publications

THE FUNDING OF CLINICAL EDUCATION

(MEDICINE)

IN THE PROVINCE OF ONTARIO

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PHASE II

RECOMMENDATIONS FOR CHANGE

January, 1977

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INTRODUCTION

In September of 1975, a report entitled "The Funding of Clinical Education (Medicine) in the Province of Ontario", represented the completion of a survey of the manner in which the clinical education system in medicine was financed and issues associated with the system.

Subsequently, the report was reviewed by the Health Sciences Education Committee of the Province, and a Task Force was established to continue with a second phase of the study. The essential purpose of this phase was to make recommendations for improvements to the system of financing.

This report represents the recommendations of the Task Force resulting from reasonable consensus.

The recommendations made in this report have been made with a view to:

1. Clarifying areas of impreciseness.

2. Constructing an information system for management and planning of the system.

3. Defining the nature of crucial relationships.

4. Protecting the essential need for flexibility between centres.

Recommendations for detailed methodologies of management have, in the main, been avoided. The Task Force feels strongly that attempts to delineate operating and administrative systems in detail will only serve to reduce the flexibility required if each centre is going to fulfill its own mission in its unique way. The statement was made, in the Phase I report, that in spite of all difficulties noted, the system has worked and served the Province and the country well. Attempts to reduce it to a set of common rules and procedures would, in the opinion of the Task Force, serve only to reduce the system's effectiveness. Major changes in the system will come about only as a result of slow, evolutionary change. The challenge is to let this change be managed at the appropriate levels in a way that best suits highly differentiated needs.

Review of Findings: Phase I

The original study described a series of problems associated with the current methods of financing the system of clinical education in the Province of Ontario.

Major issues were identified in whole or in part in the system as follows:

1. There were a number of problems resulting from inadequate integrative mechanisms at all levels. Particular difficulties arose as a result of lack of integration between the funding from the two involved government ministries.

2. Information systems were generally either non-existent or disjointed and, as a result, management of the system proved difficult.

3. Management expertise in the system was limited.

4. In particular, the conditions of T & R (Treatment and Rehabilitation) funding by the Ministry of Health, were proving to severely constrain effective financial management of the system.

5. The heavy dependence on volunteers, especially because of a perceived decrease in physician income-generating capacity, made the system appear vulnerable to a possible withdrawal of teaching on a voluntary basis.

6. While there was no evidence that clinical teachers benefit financially by virtue of services provided by students, a perception that such is the case existed strongly in the minds of a number of people at various levels.

7. There did not appear to be a system for evaluating the costs and benefits of the system.

While there were a number of specific issues identified, the foregoing reflects the major problem areas requiring resolution.

Terms of Reference: Phase II

The Terms of Reference for Phase II (the study of which this report represents a conclusion), were finally developed as follows:

"To recommend in detail and with adequate descriptions of operating and administrative systems:

1. A new method for distribution and allocation of T & R funds (including a new name) within the following limits:

   a) Ministry of Health allotment of these funds shall be by formula based on the numbers of undergraduate and postgraduate students in each school and in an amount to be determined by the Ministry.

   b) Because T & R funding is shared with the Federal Government under the Hospital Insurance and Diagnostic Services Act, funds must be flowed through the hospital system. The university should continue to pay clinical teachers with the funds that flow from the Ministry of Health through the various affiliated hospitals to the university. A designated hospital may be required to accept responsibility for flowing funds to community-based family practice teaching groups.

   c) Allocation of funds shall be to clinical teachers under the direction of the individual faculty of medicine. Such allocations should not be directly tied to provincial medical manpower needs, but should contribute to the overall ability of the medical schools to carry out their various missions, recognizing that a major mission is the education of the various types of physicians in reasonable relation to the changing medical manpower needs of Ontario and Canada. In order to ensure that education programs and resources are appropriate for the preparation of physicians to meet Canadian and provincial manpower needs, there should be continued and further developed the collaborative arrangements which have been initiated (the Boone Committee).

d) There will be no ceilings on payments to individual teachers and no matching with "hard" university funds will be required.

e) Lists of recipients with their appointments and amounts of their payments will be provided to the Ministry of Health.

f) Recommendations will be required for new methods of funding secretarial staff and provision of office space.

2. A new method of remunerating part-time (voluntary) clinical teachers for loss of service income by time devoted to teaching.

3. A method of providing meaningful accountability for use of OHIP fees by clinical teachers and medical staff associations. This must include an accounting method which will enable double payment (payment to faculty members for services provided by interns and residents outside the Code of Ethical Billing of the Ontario Medical Association), to be detected and will ensure that ceilings are not exceeded.

4. A method of better relating costs to benefits in the system.

It is understood that all recommendations must be capable of implementation within existing cost constraints."

* * *

During the course of the study, as a result of recommendations made by the Task Force, the Ministry of Health outlined a new policy in relation to the distribution of T & R funds. This new policy is reflected in the letter distributed to Task Force members at its meeting in September, 1976, and attached as Appendix A.

The Task Force

The Task Force was composed of the following members:

Dr. J.S.W. Aldis,	Chairman, Ministry of Health
Dr. I.W. Bean,	Associate Professor, Department of Family and Community Medicine, University of Toronto.
Mr. P.B. Blewett,	Executive Director, University Hospital, London, Ontario
Dr. G.G. Caudwell,	Ministry of Health
Mr. O. Clusiau,	Ministry of Health
Dr. W.J. Dunn,	Dean of Dentistry, University of Western Ontario
Reverend R. Guindon,	Rector, University of Ottawa
Mr. J.B. Hansen,	Ministry of Health
Dr. R.B. Holmes,	Dean, Faculty of Medicine, University of Toronto
Dr. A.L. Linton,	Professor of Medicine, University of Western Ontario
Mr. C. Mecredy,	Ministry of Colleges & Universities
Dr. J.F. Mustard,	Dean, Faculty of Health Sciences, McMaster University
Dr. B.J. Nickoloff,	Assistant Professor, Department of Anaesthesia, Queen's University
Mr. J.D. Snedden,	Executive Director, Hospital for Sick Children, Toronto, Ontario
Mr. M.F. Tarleton,	Ministry of Colleges & Universities

Additional Ministry of Health personnel in attendance at some of the meetings included:

Dr. B.A. Buchanan
Dr. G. Gold
Mr. T.R. Greer

Consultants to the Task Force were Dr. C.W. Birkett and Mr. R.W. Johnston of Hickling-Johnston Limited.

* * *

Meetings

The Task Force met on:

April 27, 1976
May 25, 1976
June 15, 1976
July 27, 1976
September 14 & 15, 1976
November 1, 1976
November 30, 1976

The last meeting of the Task Force resulted in the recommendations of this report. Working papers were provided by the consultants for the third, fourth and fifth meetings.

As a result of these meetings, the Task Force has promulgated a set of recommendations which should improve the current system in a manner designed to retain those features which make it an effective educational program.

This report addresses first, a set of "General Issues" which represent a fundamental basis upon which ongoing revisions should be based.

Second, a set of recommendations are presented for "Specific Issues" which reflect the clauses of the Terms of Reference.

A GENERAL ISSUES/RECOMMENDATIONS

The Task Force has identified General Issues as follows:

1. The issue of appropriate teacher definition.
2. The issue of a funding policy.
3. The issue of a funding methodology.
4. The particular issue of funding Pathology, Radiology, and Psychiatry.
5. The issue of integration of and coordination in the system of clinical education (medicine).

In dealing with these issues, the Task Force has adhered to the fundamental that clinical education is, de facto, a partnership of education and service in which neither should dominate the other. In this context a clinical teacher must have, and must be subject to systems that are consistent with, a dual accountability to education and service. This principle is considered critical to the successful management of the system of clinical education.

Teacher Definition

1. *It is recommended that, henceforth, a full-time clinical teacher be one who:*

   a) has a university-defined full-time appointment;

   b) has a clinical appointment at an affiliated teaching institution;

   c) shall be jointly appointed by the university and the affiliated teaching institution;

   and further, that these appointments document:

   i) an explicit description of the teacher's joint responsibilities to education, service and research and thus his responsibilities to the university and the affiliated teaching institution;

ii) an agreement to provide service wholly within the context of his defined responsibilities as a clinical teacher;

iii) an agreement to periodic review of the teacher's role and responsibilities;

iv) an agreement as to remuneration (salary and clinical earnings), inclusive of an upper limit and a method of auditing according to accepted accounting practice.

v) an agreement that service-generated income in excess of the contractual upper limit and agreed practice expenses become revenue to the university at the departmental or faculty level;

vi) a description of the joint responsibilities of the university and affiliated teaching institution for the provision of fringe benefits, secretarial support and office space and furnishings.

It is recommended that, where such agreement does not exist, a teacher be classified as part-time.

Rationale:

In order for each University to carry out its educational mission, it must assure itself a core of professionals with a prime commitment to the University's educational programs, and a willingness to work within the functional framework of the Medical School. To attract and retain these professionals, and to obtain optimum academic return, the University must be able to provide an appropriate degree of support and security. To the extent that all clinical teachers provide patient care and thereby generate service income, the University must have mechanisms of accountability to ensure that teachers contribute to educational programs in concert with agreed responsibilities.

Thus the full-time clinical teacher should have a relationship with the University and affiliated teaching institution that clearly identifies the responsibilities of each party to the agreement and further establishes mechanisms of accountability.

Current classifications of teachers are both complex and confusing. While the simplicity (and relative inflexbility) of the definition contained in the recommendation may seem inappropriate in such a complex area, it is the view of the Task Force that it is necessary. Part-time teachers are essential to the continuing effectiveness of the educational system. It is essential that maximum flexibility be allowed to accommodate a variety of part-time teacher relationships.

A final, and important point to note is that operational attainment of this objective may take some time to achieve, especially in light of some currently existing relationships. Universities should strive for concurrence with this recommendation in a three-year time frame.

Funding Philosophy

2. *It is recommended that the system of clinical education (Medicine) continue to be funded from multiple sources, inclusive of the Ministry of Colleges & Universities, the Ministry of Health, private contributions, research agencies and student fees.*

Rationale:

The Task Force utilized, as a starting point for discussion, the facts that:

a) the statutory responsibility for post-secondary education rests with the universities;

b) the statutory responsibility for the delivery of hospital care rests with the hospitals;

c) the statutory responsibility for the delivery of medical care rests with members of the medical profession.

and that the two Ministries should ensure funding of these activities in a manner that will allow the agencies to meet their statutory responsibilities.

Were the clinical education system less complex, the simplicity inherent in these facts might allow for clearer fiscal responsibilities. However, the system

is complex, as evidenced by the inseparable teaching/service activity of physicians, MCU payments for nursing and medical technologist training, and MOH payments to universities for primary care training.

It is the belief of the Task Force that the "tension" created in the system by such cross-funding mechanisms has been a fundamental force in maintaining the "dual responsibility" (service and teaching) outlook and thus the continued effectiveness of the clinical education system.

Funding Methodology

3. *It is recommended that a policy of global budgeting pertain throughout the system of established clinical educational programs.*

Rationale:

While of a general nature, this recommendation is intended by the Task Force to emphasize the need for a fundamental funding philosophy which will hold the constituencies responsible for resource allocation, but which will allow the individual flexibility deemed important for each of the teaching centres.

Currently, MCU funds are distributed in a global fashion both from the Ministry to Universities and from Universities to Faculties. A later recommendation in this report, referable to T & R funding, treats this source in like manner.

The Task Force feels that with respect to funds flowing to or through hospitals for teaching purposes, an "educational globe" should be constructed within the hospital global budget, and should consist of:

a) T & R Funds;

b) secretarial support costs;

c) office space and supplies costs;

d) stipends for students/residents;

e) other such funds as are intended for hospital-based health sciences education.

The Task Force is of the opinion that the development of such a globe holds considerable promise for identifying the hospital-related educational costs of clinical education and thus, will assist in clarification of the hospital role in the system.

Exceptions to the General Rule

The Task Force recognizes the need, in certain situations, for funding agencies to operate other than as recommended in this report. These situations are as follows:

a) Where categorical funding for new or special programs is provided directly to Faculties;

b) Where new funds are provided to or through hospitals for new programs;

c) Where a detailed review of the disposition of funds is felt necessary for evaluative purposes.

In such situations it may be necessary for funding agencies, in order to fully understand both resource allocation and resource requirements, to have detailed information available for evaluative and planning purposes.

With respect to new programs, the Task Force believes that, as they become established and stable, their funding should then be "folded" into the global budget wherever possible.

Particular Issue (Pathology, Radiology & Psychiatry)

4. *It is recommended that, in order to achieve academic objectives in pathology, radiology and laboratory medicine, there be established full-time positions with responsibilities similar to those of full-time clinical teachers; and*

It is recommended that a Task Force be established to develop cost-sharing arrangements that take into account dual responsibility for service and academic duty; and

It is recommended that the same principles apply to psychiatrists in provincial mental institutions that are part of the clinical teaching program.

Rationale:

For a number of historical reasons relative to hospital insurance programs and governmental - hospital financial relationships, these specific types of physicians have not been fully incorporated into clinical teaching. As a result, the Task Force feels, particularly in the laboratory sciences and radiology, academic programs have suffered.

Laboratory physicians and radiologists whether salaried by the hospital or a fee-for-service basis, have become virtually entirely dependent on service-generated income for their support. As well, certain funds have not, by virtue of legislation, been available to support their education activity. It is the view of the Task Force that special measures may be required to fully integrate these specialties into the educational framework.

The situation with respect to Ontario Hospital based psychiatrists is also complex, but in situations in which they are part of the teaching staff arrangements they should be funded in the same manner as other clinical teachers.

The Task Force feels it can establish (as it has done) basic principles for clinical education, but does not feel it can, with its current representation, deal with the details of resolving these particular issues and therefore urges the formation of a small Task Force to do so.

Integration/Coordination

5. *It is recommended that the current Health Sciences Education Committee (previously known as the Senior Coordinating Committee) be expected to play a more significant role in the future development of health sciences education and be strengthened by creating a small secretariat for clinical education with representation from both Ministries.*

Rationale:

The Task Force believes that the public interest and the needs of the system demand a better integrated government approach to problem-resolution and planning. It considered recommendations for the development of a new inter-ministry agency, for the formation of a special secretariat reporting to the Policy Field Secretariat, and for the formation of a new government commission. These alternatives covered a wide range of possible legislative action and a broad spectrum of responsibility for advising, formulating policy and, in fact, administering the total system.

The recommendation made, represents a consensual view that the current Health Sciences Education Committee has developed an understanding of a very complex system, and should be encouraged to continue to bear prime responsibility for inter-ministry coordination. The Task Force would urge the ministries involved to consider the propriety of developing an "expert secretariat" by the transfer of experienced people from a unifocal ministerial setting to serve this committee, and assure its successful liaison with the joint subcommittee of O.C.H. and O.C.U.A. hereinafter recommended.

6. *It is recommended that the Province establish a sub-committee of the Ontario Council of University Affairs, with representation from the Ontario Council of Health to be a vehicle for impartial review of, and to make recommendations concerning, government policy on matters related to Health Sciences Education in the Province.*

Rationale:

The Task Force considered a number of mechanisms which might usefully ensure ongoing dialogue among, and better integration of, the views of the various constituencies involved in the Health Sciences Education system. Included were:

a) The appointment of a sub-committee of the Ontario Council of Health and Ontario Council of University Affairs, as recommended;

b) Continuation of the current Task Force as an ongoing advisory body reporting to government at the level of the Health Sciences Education Committee;

c) Development of a new corporate agency modelled after O.C.U.A. and appointed by the Lieutenant Governor in Council to act as a public forum for review of government policy in the area of Health Sciences Education, and to act in a public advisory capacity;

d) The appointment of a sub-committee of O.C.U.A. with representation from the Ontario Council of Health.

There are differing viewpoints as to which of the foregoing was the best mechanism. The Task Force leans toward alternatives b) and d), the latter being somewhat preferred for administrative reasons. More important than a definition of the mechanism of the Task Force, is the principle that a group of knowledgeable people from the various constituencies provide a forum for continuing evaluation of Health Sciences Education in the province. Such a group would provide valuable input to the decision-making of the Health Sciences Education Committee.

The Task Force wishes to emphasize the need to acknowledge the very real problems of Health Sciences Education other than in Medicine alone. The funding of Clinical Education in these other disciplines, as noted by Dr. W. Dunn, Dean of Dentistry at the University of Western Ontario, needs review such as has been accorded the discipline of Medicine.

B SPECIFIC ISSUES/RECOMMENDATIONS

In this section, those specific items noted in the Terms of Reference are discussed as follows:

1. T & R Funds
2. Part-time teacher remuneration
3. Accounting for OHIP claims
4. Evaluating costs and benefits.

T & R (Treatment & Rehabilitation) Funds

1. *It is recommended that those funds heretofore designated as 'T & R' funds continue to be so designated.*

Rationale:

The Terms of Reference suggest that a new name for T & R (Treatment & Rehabilitation) funds might be appropriate. It is the feeling of the Task Force that 'T & R' has become an acronym, the financial/funding meaning of which is fully understood by those dealing with this particular source. It sees no value in renaming this source.

2. *It is recommended that the Ministry of Health continue to provide T & R funds to the system of clinical education.*

Rationale:

In keeping with recommendation A(2), the Task Force believes that multiple source funding of the system requires continued direct involvement of the Ministry of Health.

3. *It is recommended that T & R funds continue to be allocated to Universities on the basis of the present formula mechanism.*

Rationale:

The Task Force is of the opinion that the method for determining T & R funds allocation should continue to be on the basis of a formula wherein a unit value is ascribed to each type of student (undergraduate and postgraduate), wherein the dollar value of a unit is determined by the government, and wherein funds are allocated according to student counts. Student counts should be the same as those supplied to the Ministry of Colleges & Universities by the Universities.

4. *It is recommended that each health sciences complex be required to indicate, no later than December 31, 197?, whether T & R funds be flowed:*

(a) through a number of teaching hospitals

(b) through a single teaching hospital

and, failing such indication, the Ministry of Health continue its practice of flowing T & R funds through "multiple paymasters".

Rationale:

The Task Force considered arguments in favour of the single "paymaster" concept, the "multiple" paymaster concept, and the longer-term possibility of direct payment to Faculties.

The single "paymaster" concept was viewed as being administratively efficient, and better suited to the resolution of problems associated with the funding of community-based (as opposed to hospital-based) teaching.

The multiple "paymaster" concept was felt essential by some in that it provided yet another focus for university/teaching hospital liaison. As well, it is more practical in terms of the management of the institutional "educational globe" recommended.

In the event that a centre should elect the option of a single "paymaster" institution, appropriate accounting "transfers" should be made so that the accounts of each of the affiliated teaching institutions reflect in their educational globe, expenditures made for clinical education.

The possibility of direct payment to universities is currently constrained by the understanding upon which the costs of these funds are shared at the federal and provincial levels. Furthermore, although the mechanism has significant administrative appeal, it overlooks the fact that T & R funds are designed to support clinical education in the hospital context with the necessary attendant educational administration.

Thus, the Task Force believes that each centre should determine the mechanism which best suits it and attendant problems should be resolved at the level of faculties and teaching hospitals.

5. *It is recommended that such new funds as may be provided from time to time by the Ministry of Health to meet special needs (such as primary care training), be flowed to faculties through an appropriate mechanism and be accounted for separately until such time as they have stabilized in the sense of utilization and volume.*

Rationale:

Preliminary concern was expressed that apparent plans by the Ministry to provide additional funds for the community-based education of primary care physicians might prove, in the long term, to cause problems such as those caused by the historic manner in which T & R funds have been provided. The Task Force feels, however, that "designated funding" as proposed is both acceptable and appropriate in the short term, and can only be done effectively in the Ministry of Health context. Thus, it seems appropriate for these funds to be determined and flowed in the same general manner, and by the same methodology, as T & R funds, and that they constitute a separate and distinct segment of the previously recommended "educational globe" for at least a one to two year period. After the initial period, and according to previously enunciated principles, specifically designated funds should be folded into the T & R formula mechanism

6. *It is recommended that the total of T & R funds made available be such as to meet the objectives for which they are provided.*

Rationale:

The prerogative of government to establish budgets is recognized by the Task Force. However, the members feel it important to provide a summary of its deliberations relative to the amounts of funds provided by the T & R mechanism.

There was general agreement that, in the absence of significant shifts in the number of students enrolled, a major concern is to be able to meet reasonable compensation adjustments (as might be required to offset or partially offset the inflationary effect) for clinical teachers.

The Task Force wishes to express its concern about the degree to which increased sophistication of medical care affects the resource costs of clinical teaching. The concept is best described in the context of an example:

> As advances in technology have increased the sophistication of the medical care of myocardial infarction, so the training required for students in cardiology requires more educational input from clinical teachers. Training in the use of cardiac monitors, pacemakers, and defibrillators represents an 'add-on' to the necessary basic training in diagnosis and therapy.
>
> While we might suspect that such 'add-ons' may be offset by the removal of other, less necessary, components of the educational curriculum, such is not necessarily the case. To the extent that the educational content increases while the length of training remains fixed more time is required of the clinical teacher to be at the student's side.

The Task Force has no recommendations as to methods of estimating the impact of these increasing costs, but notes that the effects discussed must be considered by the funding agency in the context of the objectives of the educational system.

7. *It is recommended that the allocation of T & R funds be determined by individual faculties in order that the various and unique characteristics of each centre may be accommodated; and further, that historic constraints requiring matching with other funds and absolute limitation of the amounts of payments to individual teachers' compensation be removed.*

Rationale:

A major problem identified in the Phase I study related to some very specific constraints attached to the disbursement of T & R funds, constraints which severely limited intercentre flexibility. During the course of Phase II of the study, the Ministry of Health made revisions to T & R funding much in keeping with the recommendations made in this report. A letter, dated September 10th, 1976, and outlining these changes is attached as Appendix A.

8. *It is recommended that the University salary for full-time clinical teachers have a component of both T & R and University funds.*

Rationale:

The Task Force has some concern that the removal of "matching" requirements for T & R funds could lead, over time, to situations wherein full-time clinical teachers might be remunerated totally without university funds. In keeping with the principles underlying multiple source funding and a partnership of education and service, the Task Force believes it important for all clinical teachers to be remunerated from both sources of funds in some measure.

9. *It is recommended that secretarial support to clinical teaching be provided on the basis that:*

   a) *Secretarial staff be formally designated as employees of the institution in which they are working.*

   b) *Financial responsibility for this support function be held by the university and the affiliated teaching institution.*

c) *Determination of secretarial requirements be a joint responsibility of the University and the affiliated teaching institution taking into account the needs of the clinical teacher.*

Rationale:

Major requirements to resolve the issues pertinent to the secretarial support function as outlined in the Phase I study include a need to:

a) clearly enunciate an employer-employee relationship

b) clearly enunciate the locus of responsibility for allocating the payment for secretarial staff

The Task Force views it important to establish that secretarial support to the clinical teaching function be identified as employees of the institution in which they work, and thus be subject to the personnel systems of that institution.

Likewise, the Task Force has indicated its preference that secretaries to clinical teachers clearly be identified as components of the clinical education system by virtue of its recommendation (A3) that the institutional component of secretarial salaries be part of the "educational globe".

With respect to the payment of secretaries, it seems clear that their activity is as inextricably linked to the service/education mix as is that of the clinical teachers whom they support. Thus, the recommendation is that there be a joint responsibility for the costs involved in providing this support function.

With respect to the university's contribution, the Task Force feels that the issue of the source of its contribution is irrelevant. It is felt that these monies may emanate from service-generated, educationally-generated, or even research-generated funds.

Given the foregoing, the Task Force is of the opinion that the natural sequel is that the decisions with respect to the allocation and distribution of secretarial staff must be of mutual and equal concern to both the institutions and universities. Thus, the recommendation is that these decisions be the equal and joint responsibility of the two parties.

10. *It is recommended that the costs of office space necessary to clinical education be included in the educational "globe" of the institution.*

Rationale:

In keeping with the philosophy of other recommendations, the Task Force feels that the education globe of institutions should include the costs related to the provision of office space for full-time teachers.

Remuneration of Teachers other than Full-Time

11. *It is recommended that the contribution of clinical teachers other than full-time be recognized by academic appointment, research assistance and/or appropriate remuneration mechanisms, such as secretarial support, honoraria, sessional payment and fringe benefits.*

Rationale:

Phase I of the study indicated that clinical teachers categorized as "minor part-time" or "volunteer" contributed very substantially to the system of clinical education. As well, it indicated that a significant number of these teachers were beginning to re-assess the cost/benefit equation of their involvement, particularly in financial terms.

The Task Force knows that the spectrum of involvement in clinical teaching is very broad, and the diversity of practice such that the individual Faculties must have considerable latitude with respect to methods of recognizing this sector of the teaching community. Yet, at the same time, there appears to be a need for a Faculty focus to ensure equitable treatment for part-time teachers in the various departments and situations.

For some part-time teachers, the non-monetary benefits attributable to university affiliation, availability of residents/interns, and accessibility to research are likely to be of sufficient importance that monetary remuneration is not a requisite.

For other part-time teachers, the amount of time devoted to clinical teaching may be so significant as to absolutely require substantial compensation.

Between the two extremes are a great number of variations. One in particular is that of the community-based practitioner who accepts responsibility for teaching in the context of a full-time practice.

In light of the broad spectrum of involvement, the Task Force believes it essential to allow each of the Faculties significant latitude in the management of this issue. It is essential that there be perceived equity within Faculties, and a consistency of management; in this regard, the Task Force feels that the Office of the Dean must be in the position of monitoring Departmental practices.

The Task Force recognizes that historic methods of remuneration for clinical teaching have proven generally acceptable. The provision of honoraria or sessional payments are two clearly acceptable methods. The provision of university fringe benefits (in the absence of salary), while requiring detailed analysis according to the contracts and arrangements existing at each centre, is an opportunity to compensate the part-time teacher in a manner that has (or is perceived to have) value in excess of actual cost. It is an option that each centre is advised to investigate.

Accounting for OHIP Claims

12. *It is recommended that the Ontario Medical Association, Section of Clinical Teachers, representatives of the Medical Review Committee of the College of Physicians and Surgeons of Ontario and OHIP, discuss means of ensuring that all clinical teachers exercise their responsibility with respect to the preparation and submission of claims for service.*

Rationale:

Phase I of the study failed to show that there was abuse of the ethical billing principles enunciated by the College of Physicians & Surgeons. There has been concern relating to the non-compliance by some clinical teachers and their staff associations with the established OHIP claims procedures in effect for the profession as a whole.

While the Task Force is satisfied that clinical teachers do not benefit unduly from claims made to OHIP, it finds it difficult to understand why the established control mechanisms for OHIP claims would not be implemented with consistency across the entire profession.

In this respect the Task Force is of the unequivocal view that clinical teachers as practitioners of Medicine, are no different from the rest of the profession with respect to their responsibility for complying with the requirements of claims and records procedures. The Task Force feels that teachers failing to so comply must be subject to the same saction procedures of the College in effect for practitioners at large.

With respect to the issues surrounding the combined provision of services to patients by teachers and residents, the Task Force wishes to note that full-time clinical teachers, subject to income limitations are not in a position to benefit in a financial sense by resident services. While it would be of some interest to be able to evaluate the extent to which other than full-time teachers may benefit, the Task Force believes that Phase I demonstrated that, on balance, the OHIP system is not being abused by the clinical teaching system.

Departmental Reporting

13. *It is recommended that Faculties establish mechanisms to gather annually, from all of their Departments, information regarding the source and application of funds used by the Departments in their combined teaching, research, service and administrative activities.*

Rationale:

A significant problem discovered in Phase I was that of substantial information gaps. To a considerable extent this problem is a result of the incremental manner in which the system of clinical education has become increasingly financed from the public purse. As well as causing misunderstanding and conflict at all levels, these gaps made rational planning for and management of the system difficult.

Given the allocation of T & R and University funds from the Faculty to Departments, and given the development of an institutional "education globe", the chief additional information required relates to service generated funds. This information, given teachers' conformance to billing regulations, could be derived centrally, but such a method is fraught with major potential problems of interpretation. There seems little reason that full-time clinical teachers' fee-generation, and the contribution of that income to the clinical educational system should not be available as a component of a financial reporting/planning system.

The Task Force urges all Faculties to institute a reporting system of this nature. A standard requirement should be that each Department be able to make available, on an annual basis, a Faculty financial report consisting of an income statement and a statement of source and application of funds.

Finally, the Task Force urges Departments to establish methods of making available, to its members, information of a similar nature in order that individual teachers can develop a greater appreciation of the financial characteristics of the system. The desire for such information was expressed and noted in the Phase I report and it, in the view of the Task Force, is reasonable.

Faculty Reporting

14. *It is recommended that Faculties establish an annual report, such report to include a review, for the preceding year, of activity in each of the areas of teaching, service and research, and pertinent financial information; further, that such report outline future plans.*

Rationale:

The individual Faculties in the Province currently gather, on an annual basis, a variety of data. Annual reports may be prepared by Department for Faculties and, likewise Faculties may prepare reports, annual and otherwise, for Universities, for accreditation purposes, etc. It appears that much of the information which would be useful to those funding the system is already available in one form or the other -- the major problem is that of appropriate organization and transmittal of data.

The Task Force is of the opinion that, since the system is, in great part, publicly funded, an information system which provides the funding sources with a better understanding of the costs and the benefits of the system would be well worthwhile. Furthermore, the Task Force feels that such an information system should carry a heavy output emphasis, as opposed to a system oriented towards inputs of time, energy and dollars.

Thus, the recommendation that Faculties prepare an annual report, which report would be distributed to the major constituencies in the system, inclusive of the Universities, the Health Sciences Education Committee, Teaching Hospitals and internally in each Faculty as deemed necessary.

This annual report should include, at a minimum:

1. A review of the educational program inclusive of student loads, staff complements, and major scholarly activity of Faculty.

2. A review of service activity inclusive of standard in-patient and out-patient service data, and non-hospital based service teaching.

3. A review of research activity.

4. A financial review inclusive of a statement of source and application of funds.

5. A plan for the next academic year by program, and a preliminary budget.

6. A forecast of plans for the next five years with an estimate of financial requirements.

Appendix B represents a suggested format for such an annual report.

With access to such information, it is hoped that there may be improved dialogue between the various constituencies in the system, and further that policies made regarding Health Sciences Education may better reflect the status, aspirations and capabilities of the clinical educational system in Ontario.

APPENDIX A

Ontario

of the
y Minister

Ministry of
Health

416/965-2437

Hepburn Block
Queen's Park
Toronto Ontario
M7A 1R3

September 10, 1976

Dr. R. B. Holmes,
Dean,
Faculty of Medicine,
University of Toronto,
Toronto, Ontario M5S 1A8.

Dear Dr. Holmes:

The Task Force on the Funding of Clinical Education has recommended a revised policy, which the Ministry has accepted, for the distribution of T&R funds. The new policy in regard to these funds will be effective July 1, 1976:

(a) Ministry of Health allotment of these funds shall be by formula based on the numbers of undergraduate and post graduate students in each school and in amount to be determined by the Ministry.

(b) The clinical teachers will be paid for the administration and direction of hospital programs with "T&R" funds according to the direction of the university, or, alternately, if the university has paid these practitioners, the hospital can reimburse the university the appropriate amount. A Hospital will be responsible for designated satellite community-based family practice teaching groups, including the management of funds paid to physicians for the administration and direction of the program of such groups.

(c) Allocation of funds shall be to clinical teachers working in hospitals under the direction of the individual faculties of medicine.

(d) Lists of recipients with their appointments and amounts of their payments will be provided to the Ministry of Health.

....2

The policy for the allocations of funds to clinical teachers should contribute to the overall ability of the medical schools to carry out their various missions, recognizing that a major mission is the education of the various types of physicians in reasonable relation to the changing medical manpower needs of Ontario. In order to ensure that education programs and resources are appropriate for the preparation of physicians to meet provincial manpower needs, there should be continued and further developed collaborative arrangements which have already been initiated. It should, however, be noted that primary care - and in particular family practice - is a provincial priority. We will therefore expect an increasing allocation of funds into community-based primary care programmes.

There will no longer be any requirement to match the Ministry's T&R fund allocation with BIU and overage funds and the $15,000 ceiling will be removed. The Ministry, the universities and the teaching hospitals will discuss further the possibility of flowing T&R funds through a "paymaster" hospital for each of the five health science centres.

The problem of devising new methods of funding secretarial staff and provision of space cannot be resolved at this time, but will be forwarded to the Task Force on Funding of Clinical Education for further discussion. Until the question has been resolved, universities should not request teaching hospitals to contribute to salaries for additional secretaries for members of the teaching staff.

Yours sincerely,

W. Alan Backley.

APPENDIX B

SUGGESTED ANNUAL REPORT FORMAT

FACULTIES OF MEDICINE

Educational Programs

a) Program Reviews by discipline.
b) Student data by type, students graduating.
c) Faculty complement by type, by discipline.
d) Plans for coming year by program.

Research Programs

a) Summary of research completed and in process.
b) Plans for coming year by project.

Service Programs

a) Service programs by hospital, by type.
b) Basic hospital data by affiliated hospital.
c) Plans for coming year by hospital, by program.

Financial Information

a) Source and application of funds by department.
b) Statement of remuneration paid
    i) in aggregate for full-time teachers
    ii) in aggregate for part-time teachers
c) Budget plan for subsequent years.
d) Financial requirements for subsequent 5 years.

APPENDIX C

CLINICAL TEACHERS AND MEDICAL EDUCATION

During the past fifteen years the medical schools in Ontario have increased the time being devoted to clinical subjects and clinical teaching with a corresponding decrease in theoretical and didactic methods. In addition the schools have adopted in various forms "systems teaching" in which the material presented is organized not as discrete subjects of anatomy, physiology, pharmacology, pathology, and so on, but in terms of biological systems with emphasis on human biology. In order to ensure that the students have as broad a perspective as possible about health and health care, attempts have been made to introduce the subject of community health (family practice, social and preventive aspects of health care) early in their studies and as part of the clinical clerkship and electives programs. The schools of medicine have been given increasing responsibility for postgraduate education and are heavily involved in continuing medical education. This allows close integration with the undergraduate programs and makes it possible to avoid unnecessary duplication, lost momentum, and general inefficiency. In fact, upwards of 80% of the overall educational effort of a Faculty of Medicine is assigned to the area of clinical teaching, most of it in a hospital or community setting, where clinical service activities are taking place.

These developments have been achieved through the establishment of full-time faculty. The responsibilities of these individuals cover a broad spectrum of activities all the way from someone who has a primary academic focus and very limited clinical responsibility, to someone with a major clinical focus in service and administration and a smaller academic focus. This spectrum of clinical teacher activities includes:

1) the human biology instruction in the system's teaching programs which is an important and powerful tool in the understanding and management of human disease.

(continued)

2) The teaching of clinical skills to undergraduate students in all years of the undergraduate program, and the responsibility for the evaluation of the professional attributes of clinical clerks, interns, and residents for the purposes of the M.D. degree, licensure, and certification by the Colleges.

3) The instruction and supervision of postgraduate students;

4) Programs in continuing medical education;

5) The development of special studies for electives for students so that they can get a better appreciation of the diversity in health and health care;

6) Taking part in the development and operation of a continuum of clinical education beginning with the undergraduate and continuing with the postgraduate student as the individual progresses to completion of training.

7) Taking part in the planning, execution, and administration of education programs and health services in relation to the service needs of the institution or district in which clinical education takes place; (In some centres this may be the only available resource for certain components of tertiary care);

8) Taking part in, and in some cases, carrying out health research projects;

9) Providing exemplary patient care in which they must be able to work with and relate to their colleagues in the community.

(continued)

Regardless of which part of the spectrum an individual teacher fits into, his daily activities likely embrace several of these functions. For each clinical teacher the proportion of each activity may vary from time to time. Moreover, any one clinical teacher may, in the course of his daily activities, perform two or more of these functions simultaneously. Thus, in order to maintain programs in medicine that can provide a balanced education in theory and practice, it is essential to have physician teachers who have a dual responsibility to education and to service. Any re-arrangement of the existing system of financing should be so organized that it optimizes this dual function and should aid the educational institutions in continuing their development of programs based on the broad human relation aspect of health and health care, and on an ongoing integration through undergraduate to post-graduate education.

The increased use of office-based settings in the community for clinical teaching has to be recognized along with the special problems including financing associated with this form of clinical teaching.

Furthermore, the role of the part-time clinical teacher must be considered and any new arrangements should take into account the very major contributions of these physicians.


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